***Members***

***Sen. Patricia Miller, Chairperson***
***Sen. Greg Server***
***Sen. Ron Alting***
***Sen. Beverly Gard***
***Sen. Steve Johnson***
***Sen. Connie Lawson***
***Sen. Marvin Riegsecker***
***Sen. Allie Craycraft***
***Sen. Billie Breaux***
***Sen. Earline Rogers***
***Sen. Vi Simpson***
***Rep. Charlie Brown, Vice-Chairperson***
***Rep. Brian Hasler***
***Rep. William Crawford***
***Rep. Susan Crosby***
***Rep. John Day***
***Rep. Win Moses***
***Rep. Scott Pelath***
***Rep. Peggy Welch***
***Rep. Vaneta Becker***
***Rep. Timothy Brown***
***Rep. Mary Kay Budak***
***Rep. Gary Dillon***
***Rep. David Frizzell***
***Rep. Gloria Goeglein***

# HEALTH FINANCE COMMISSION

***Legislative Services Agency***
***200 West Washington Street, Suite 301***
***Indianapolis, Indiana 46204-2789***
***Tel: (317) 233-0696 Fax: (317) 232-2554***

***LSA Staff:***

***Al Gossard, Fiscal Analyst for the Commission***
***Carrie Cloud, Attorney for the Commission***
***Casey Kline, Attorney for the Commission***

***Authority: IC 2-5-23***

## MEETING MINUTES[1]

**Meeting Date:** September 26, 2001
**Meeting Time:** 1:00 P.M.
**Meeting Place:** State House, 200 W. Washington St., Senate Chambers
**Meeting City:** Indianapolis, Indiana
**Meeting Number:** 2

**Members Present:** **Sen. Patricia Miller, Chairperson; Sen. Greg Server; Sen. Ron Alting; Sen. Beverly Gard; Sen. Steve Johnson; Sen. Connie Lawson; Sen. Marvin Riegsecker; Sen. Billie Breaux; Sen. Earline Rogers; Sen. Vi Simpson; Rep. Charlie Brown, Vice-Chairperson; Rep. William Crawford; Rep. Susan Crosby; Rep. John Day; Rep. Win Moses; Rep. Scott Pelath; Rep. Peggy Welch; Rep. Vaneta Becker; Rep. Mary Kay Budak; Rep. Gary Dillon; Rep. David Frizzell; Rep. Gloria Goeglein.**

**Members Absent:** **Sen. Allie Craycraft; Rep. Brian Hasler; Rep. Timothy Brown.**

Sen. Patricia Miller, Chair of the Commission, called the meeting to order at 1:40 p.m.

## *Update on the Immunization Registry*

### *Dr. Gregory Wilson, Commissioner of the State Department of Health.*

Dr. Wilson provided an update on the progress of establishing the state's immunization registry. Dr. Wilson stated that an immunization program is an essential component in the prevention of illness and that the improvement of immunization rates will require an integrated system,

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

including an immunization registry and intervention on a local basis in geographical areas which have inadequate vaccinations. He stated that an immunization registry can: (1) identify individuals who have not been adequately immunized; (2) identify geographical areas which have been underimmunized, allowing targeted public health education; (3) provide an automated system to send reminder messages to families; (4) ensure that individuals do not receive duplicate immunizations; and (5) maintain a computer database of immunization lot numbers so that a rapid, efficient notification of individuals can be made if a recall is necessary.

Dr. Wilson stated that the establishment of an immunization registry is a high priority for the State Department of Health (SDH). He added that the SDH has entered into an agreement with the national Centers for Disease Control and Prevention (CDC) to obtain $800,000 of federal funding for start-up costs and additional funding for yearly maintenance of the registry. There would be no state match required for initial implementation. A national vendor with a fully developed web-based immunization registry system will be used.

Dr. Wilson added that the contract will be in place by late 2001 or early 2002. Selection of a vendor will occur in early 2002 with implementation commencing by the third quarter of 2002. He described the proposed system as being web-based, voluntary for both the public and providers, and consent would be required for "opting in". He also stated that there would be possible development of data sharing between the Women, Infant and Children (WIC) program, the immunization registry, and lead testing. (Dr. Wilson's written testimony is available as Exhibit 1.)

## ***Monitoring, Identification, and Methods to Reduce Birth Defects***

***Dr. David Weaver, Professor of Medical Genetics and Director of Clinical Genetics, Indiana University School of Medicine.***

Dr. Weaver provided information regarding the surveillance of birth defects in Indiana. He stated that 40% to 50% of admissions to children's hospitals are a result of birth defects and/or genetic disorders. He added that currently Indiana does a poor job of collecting data on birth defects and genetic disorders and making sure that the affected children receive needed services and long-term management of their problems.

Dr. Weaver briefly described birth defects and genetic disorders, and he also provided a brief history of birth defects surveillance. He stated that Indiana established a passive birth defects surveillance program called the Birth Problems Registry which records any recognized birth defect or low birth weight. The aggregate data are then reported annually by the State Department of Health. The program is funded in part by a two-dollar fee for birth certificates issued by the SDH. However, the data has been little utilized and is not very accurate. Dr. Weaver proposed that there be expanded utilization of birth defect data for the purpose of developing a child health profile, for increased epidemiologic activities, and for policy-making regarding birth defects and low birth weight.

Dr. Weaver also suggested that the state take the following actions: (1) Initiate a modified active birth defects surveillance program; (2) Develop a more adequate epidemiologic program at the Indiana State Department of Health; (3) Initiate an Indiana Child Health Program; (4) Develop a system for referral of identified children; (5) Develop an education component for the Indiana Birth Problems Registry; and (6) Provide adequate funding.

Dr. Weaver presented estimates of the costs that would be incurred and suggested that the costs would be more than offset by reduced expenditures resulting from these problems. He suggested that possible funding sources include: federal grants, increasing the fee charged for

newborn screening follow-up, raising the tax on alcoholic beverages, directing some of the gambling money to these projects, and establishing a surcharge on health policies written in the state. (Dr. Weaver's complete written testimony is available as Exhibit 2.)

Dr. Weaver also provided the following articles and exhibits to the Commission.

Erickson, J. David, "Introduction: Birth Defect Surveillance in the United States", Teratology 61-1-3 (2000). (See Exhibit 3.)

Khoury, Munin J., "Genetic Susceptibility to Birth Defects in Humans: From Gene Discovery to Public Health Action", Teratology 61:17-20 (2000). (See Exhibit 4.)

Walker, Deborah Klein, "Integrating Birth Defects Surveillance in Maternal and Child Health at the State Level", Teratology 61:4-8 (2000). (See Exhibit 5.)

Listing of Indiana Genetic Advisory Committee members. (See Exhibit 6.)

***Dr. Roland Gamache, Director, Data Analysis Team, State Department of Health.***

Dr. Gamache briefly reviewed the types of birth problems that include: (1) a structural deformation; (2) a developmental malformation; (3) a genetic, inherited, or biochemical disease; (4) a birth weight of less than 2,500 grams; (5) a condition of a chronic nature, including a central nervous system hemorrhage or infection that may result in a need for long term health care; and (6) stillbirth. Dr. Gamache stated that the SDH uses the Birth Problems Registry (BPR) data to conduct epidemiologic studies and to apply appropriate preventive and control measures, to inform citizens regarding programs designed to prevent or reduce birth problems, and to make available to researchers under certain circumstances. He also reviewed the sources of data for the registry.

Dr. Gamache provided details on the adoption of the BPR rule, reviewed the guidelines that are being used in the implementation of the rule, and stated that the SDH is talking to other state health departments, the CDC, and related organizations to decide on an appropriate reporting system and sources of data. Dr. Gamache also reviewed the CDC funding opportunities.

Dr. Gamache stated that the draft rule would be sent out to several organizations for review in October 2001. The proposed rule would be published in December 2001 to January 2002 with a public hearing to be held in February 2002. The rule is to be sent to the Attorney General and the Governor in March 2002. (A written summary of Dr. Gamache's testimony is available as Exhibit 7.)

## ***Indiana Comprehensive Health Insurance Association (ICHIA)***

***Sally McCarty, Commissioner, State Department of Insurance.***

Ms. McCarty advised the Commission of recent actions taken by the ICHIA Board of Directors. The ICHIA Board voted to amend ICHIA's Plan of Operation to expand the base of health premium dollars that are assessed biannually to include the amounts paid by health stop-loss carriers to settle underlying claims. Up to now, the assessment has only been on premiums paid to purchase stop-loss coverage. Self-insurers typically purchase stop-loss coverage. Self-funded employers are protected by ERISA (i.e., regulated by the federal government) and, consequently, cannot be assessed by ICHIA. However, stop-loss carriers are regulated by the state. This change will allow ICHIA to compute assessments based on a larger pool of premium and claims dollars. Stop-loss carriers are already members of the Association, but they have

not been assessed to the full extent possible under the law. (Ms. McCarty added that applying the same principle to the underlying claims of Third Party Administrators would require a statutory change.)

Ms. McCarty added that the ICHIA Board at its February meeting approved a 27% premium rate increase for enrollees. This is the first rate increase since 1996. (Ms. McCarty's complete written testimony is available as Exhibit 8.)

***Alex Slaboskey, President/CEO of M-Plan.***

Mr. Slaboskey, speaking on behalf of the Indiana Association of Health Plans, briefly reviewed the problem facing some of the health carriers who are members of ICHIA. Because the premiums charged by ICHIA do not cover the cost of care provided to beneficiaries and because the number of enrollees is rapidly increasing, IHCIA losses are very large and growing at a double digit rate. ICHIA losses are financed through annual assessments on HMOs and health insurance companies. Mr. Slaboskey stated that the amount M-Plan paid last year to ICHIA was more than twice its net income. On the other hand, self-insured plans which cover more people in Indiana than all of the insured plans combined contribute nothing because of the federal ERISA law. Indiana law allows HMOs and insurers to use ICHIA assessments as credits against state taxes. However, much of the credits cannot be used because the assessments are in excess of tax liabilities.

Mr. Slaboskey stated that there are three possible ways to address ICHIA's financial problems: (1) reduce the losses of the ICHIA program through changes in eligibility, coverage, and premiums; (2) expand the base on which ICHIA assessments can be made; and (3) provide additional sources of funding for ICHIA. (Mr. Slaboskey's complete written testimony is available as Exhibit 9.)

Mr. Slaboskey also provided copies of the report "Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools" (Achman and Chollet, Mathematica Policy Research, Inc., August 2001). (See Exhibit 10.)

Mr. Slaboskey described in greater detail Table 1 (three states have capped enrollment), Table 3 (Indiana has the 7$^{th}$ largest enrollment out of 27 states), Table 6 (Indiana is one of only two states with no lifetime benefit maximums), and Table 9 (Indiana has the 5$^{th}$ highest cost per enrollee of the 27 states) of the report. Mr. Slaboskey also noted that Oregon and Washington base their high-risk pool assessments on the number of covered lives rather than on premiums, thus allowing the assessment of stop-loss insurers who provide coverage to self-insured plans.

***Carolyn Elliot, representing the Indiana Association of Health Plans.***

Ms. Elliot offered several suggestions for solving the ICHIA funding problems: (1) increase state funding; (2) reduce ICHIA benefits; (3) cap ICHIA enrollments; (4) raise premiums; (5) establish lifetime limits for patients; (6) cap member assessments; (7) expand the assessment base; and (8) use Tobacco Settlement dollars. Ms. Elliot also suggested several other potential methods of alleviating the problem: (1) investigate the potential of an 1115 Demonstration Waiver; (2) change the fiscal calendar and/or allow payments in installments so members can better prepare their annual budgets; and (3) adjust the tax credit formula because not all companies can take advantage of the tax credits. Ms. Elliot reiterated support for an amendment to SB 537-2001 which would have allowed a member company of ICHIA to receive a refund for the amount by which its annual assessment exceeds the value of the assessment tax credits that the company is able to claim against taxes for the same year. The liability of the state general fund is estimated to be $42 million in CY 2002. (Ms. Elliot's written testimony is provided as

Exhibit 11. The proposed amendment to SB 537-2001 is provided as Exhibit 12.)

***Kim Stoneking, Indiana Association of Health Underwriters.***

Mr. Stoneking testified on the impact of the Indiana law which limits exclusions for preexisting conditions to no more than 12 months. He stated that the law has resulted in increased costs to insurance companies and has increased the number of people who are not able to obtain individual health insurance coverage. He indicated that the number of circumstances where individual health insurance coverage has been denied or where coverage was declined by the individual has increased from 15% of all applicants before the statutory change to a rate of about 40% to 60%.

Mr. Stoneking also provided a letter from the United Security Life Insurance Company of Illinois providing additional details regarding the problem, as well as some ICHIA statistics on membership, premiums earned, and incurred losses from 1996 through 2001. (See Exhibit 13.)

***Lee Tooman, Golden Rule Insurance Company.***

Mr. Tooman stated that Golden Rule is an Illinois-based life and health insurance company licensed to do business in Indiana. Because Golden Rule is domiciled in a state other than Indiana, they are classified as a "foreign" company and, consequently, must pay premium taxes regardless of profitability (about 2% of premium in 2000). He added that Indiana HMOs pay Indiana corporate taxes equal to the greater of 1.2% of gross receipts, including premiums, or 3.4% of federal taxable income after adjustment for certain Indiana modifications. Mr. Tooman indicated that Golden Rule fails to understand how HMOs have been unable to use their full ICHIA assessments to offset their corporate income tax liability. Furthermore, he stated that if HMOs were made to pay the same premium tax as Golden Rule, the playing field would be more level, and the HMOs also could fully offset their ICHIA assessments.

Mr. Tooman added that Indiana should broaden the assessment base (as Oregon, Washington, Kentucky, Wisconsin, and Louisiana are doing) by assessing stop-loss carriers and reinsurers. Mr. Tooman also stated that the benefits of the Indiana high-risk pool plans are extremely generous in comparison to other states' plans, with no maximum lifetime benefit and only a three-month exclusion requirement for preexisting conditions. Mr. Tooman further recommended that the ICHIA funding base be broadened and its eligibility and plan design be made more consistent with other states' high-risk pool plans. (Mr. Tooman's complete written testimony is provided as Exhibit 14.)

***Jerry Steffl, Unicare.***

Mr. Steffl spoke of the need for the state to eliminate the current ban on exclusionary riders because of the ban's impact on the uninsured population, ICHIA, and the individual insurance market. These riders allow carriers to extend coverage to individuals who are in overall good health but have conditions precluding full coverage. The exclusions may last four to five years, such as for implants or carpal tunnel. Mr. Steffl stated that riders also enable individuals to purchase individual coverage as a temporary bridge to group coverage.

Mr. Steffl indicated that individuals who purchase a policy with an exclusionary rider understand the implications of not having complete health insurance, and with the riders, carriers can offer otherwise full coverage at normal rates. Exclusions present the consumer with an option on which a value judgement can be made based on price and coverage available. Mr. Steffl added that the only existing alternatives are to remain uninsured or purchase ICHIA coverage. Mr. Steffl estimates that 300 ICHIA policy holders could have been offered, and would have accepted, individual insurance coverage with a rider had one been available. Mr. Steffl added

that the cost to ICHIA of such individuals not being in the private market is approximately $110,000 per year. (Mr. Steffl's written testimony is available as Exhibit 15.)

Sen. Miller announced that there would be an informal workgroup meeting for anyone who is interested in finding a workable solution to the ICHIA problem. The meeting will be October 4 at 1 p.m. in the Senate Republican Caucus Room.

## ***Nurse Shortage***

***Earnest Klein, Executive Director, IN State Nurses' Association.***

Mr. Klein stated that health care institutions across the state are experiencing a crisis in direct care staffing, and projections show that these current shortages are an indication of the systemic shortages that will soon confront our health care delivery system. Mr. Klein summarized several of the reasons for the current staffing crisis and provided statistics regarding the dwindling supply of nurses.

Mr. Klein discussed the workplace conditions in which nurses are employed and noted that about 24% of registered nurses (RNs) in Indiana are not employed in nursing. He also noted that there are some 1,200 openings for RNs in Indiana hospitals. He added that some of the workplace conditions that nurses find troubling are (1) unsafe conditions, (2) mandatory overtime, (3) retaliation if they report unsafe practices, and (4) inappropriate staffing levels. Mr. Klein noted that using unlicensed personnel and recruiting foreign-trained nurses are not appropriate solutions to the problem.

Mr. Klein suggested that nursing education programs must be expanded to accommodate new students and make higher education more accessible; scholarships to offset tuition and other expenses are essential; and nursing education must reflect ethnic, cultural, and racial diversity. Mr. Klein also recommended that there be consistent and systematic collection and analysis of data. Mr. Klein also noted characteristics of hospitals that can aid in the recruitment and retention of nurses. (Mr. Klein's written testimony is available as Exhibit 16.)

***Faith Laird, Vice President, Indiana Health Care Association (IHCA).***

Ms. Laird stated that, while past nurse shortages have been cyclical in nature, the data indicates that the current nurse shortage will, at a minimum, last longer than previous shortages and may never correct itself. The reasons are that (1) careers in health care have lost much of their appeal; (2) nursing careers are looked at as overworked, underpaid, with a high level of liability, both clinically and financially; and (3) there is a relatively low unemployment rate. Ms. Laird added that about 800,000 nurse aide positions will need to be filled in the next seven years, nationwide. Ms. Laird also noted that survey results indicate that there are approximately 500 RN vacancies in Indiana, about 1,300 LPN vacancies, and about 3,000 Certified Nurse Assistant vacancies. (Ms. Laird's written testimony is available as Exhibit 17.)

Ms. Laird also distributed: (1) a GAO report issued July 2001 (Exhibit 18); (2) an American Health Care Association Staffing Report issued February 2001 (Exhibit 19); (3) a Databook from the Indiana RN Survey of 1997, Indiana Health Care Professional Development Commission, January 2000 (Exhibit 20); (4) a graph of the results of a survey conducted by IHCA in the winter of 2001 (Exhibit 21).

***Carol Sternberger, Chair, Dept. of Nursing, Indiana-Purdue University, Fort Wayne.***

Ms. Sternberger stated that today's nursing shortage is very real and is predicted to worsen throughout the next 20 years. She added that an additional problem is a shortage of nurse educators to train nurses. Ms. Sternberger indicated that the shortage in nurse educators is largely because of low salaries (compared to clinical practice settings); the required minimum of a master's degree in nursing; and the long hours associated with clinical faculty work. She added that there must be programs to assist nurses to obtain masters degrees and financial support to entice nurse educators. (Ms. Sternberger's written testimony is available as Exhibit 22.)

***Debra Stam, Director, Educational Services, Parkview Health Systems, Ft. Wayne.***

Ms. Stam stated that there is a nurse shortage, not only in Indiana, but across the country. The shortage is due to several factors, including more alternative career opportunities, working conditions, and low wages. Ms. Stam reviewed some of the strategies that Parkview Health Systems is undertaking to compete for nurse employees. These include: (1) surveying current staff to seek input on how to improve the work environment; (2) holding management and physicians accountable to implement action plans that address areas of improvement; (3) increasing their tuition assistance program; (4) implementing an education loan payback program; (5) providing sign-on bonuses; (6) providing universities with additional financial resources to assist in the expansion of their nursing programs, while providing additional clinical nursing experiences for their students; (7) entering into partnerships with local school systems to generate interest by primary and secondary students in nursing careers; and (8) adjusting nursing salaries to stay competitive with the local and regional markets. Ms. Stam suggested that students pursuing nursing careers need more educational and financial assistance from the state in order to complete their educational programs. (Ms. Stam's written testimony is available as Exhibit 23.)

***Angela McBride, PhD, Dean of Indiana University School of Nursing.***

Dr. McBride provided testimony on the nursing shortage and specific information on: (1) the extent of the nursing shortage nationally; (2) the reasons for the shortage; (3) Indiana's specific situation; (4) conditions within the IU School of Nursing; and (5) recommendations for strategies to address some of the issues.

Dr. McBride's specific recommendations include: (1) Work settings must support professional practice and there must be career ladders that reward education and experience; (2) Job satisfaction must be addressed through the abolition of mandatory over-time and unsafe staffing levels; (3) Recruitment efforts should generally be encouraged, particularly for youth, males, and minorities; (4) Work needs to be redesigned to enable an aging workforce to remain active; (5) Funding for nursing education needs to be substantially increased, particularly to recruit prepared faculty and replace crowded or outdated facilities and equipment; (6) Regular data collection is needed to monitor changing workforce needs and demand for specific types of nurses and should be coordinated with the licensure process; (7) Investment monies must be available to encourage technological advances that enhance the capacity of a reduced nursing workforce; and (8) Traineeships, including tuition and stipends, must be made available to encourage full-time graduate studies in order to build the next generation of nursing faculty. Dr. McBride also provided the caveat that we should avoid a strategy that would encourage huge numbers of students to apply to schools of nursing when there aren't the faculty and clinical placements to handle them. (Dr. McBride's complete written testimony is provided as Exhibit 24.)

***Vicky Kirkton, Director of the Department of Nursing, Goshen College.***

Ms. Kirkton reiterated the notion that this cycle of nursing shortage appears to be different from

previous shortages, and the response to the need has been slower. Ms. Kirkton provided several reasons why this nursing shortage is more severe.

Ms. Kirkton provided the following recommendations that would have a direct impact on enrollments in small liberal arts colleges: (1) There is a need for more scholarships and funding for nontraditional students; (2) There is a need for more scholarships and funding for second-degree students; (3) There is a need for more scholarships and funding for a diverse student population, such as Hispanics and African-Americans. Ms. Kirkton also stated her concerns about the shortage of nursing faculty. Ms. Kirkton suggested that the increase in nurse licensing fees (from $20 to $50) should be devoted to scholarships, loan packages, and other incentives to recruit more people to nursing and to assist those nurses interested in teaching. (Ms. Kirkton's complete written testimony is available as Exhibit 25.)

***Karra Cleland, Lutheran Hospital of Indiana, Ft. Wayne.***

Ms. Cleland spoke on the problem of the nursing shortage. She made the following recommendations: (1) Support the nursing schools with scholarships; (2) Provide funds to promote the nursing profession; (3) Allow the profession to use licensure fees to help promising young men and women acquire nursing degrees; and (4) Help the profession to market nursing to the general public and in the school systems. (Ms. Cleland's written testimony is available as Exhibit 26.)

***Barbara Mitchell, Executive Director, Nursing 2000.***

Ms. Mitchell provided information on the need to immediately address the nursing shortage in Indiana. Ms. Mitchell also reported on some key strategies that resulted from the Indiana Nursing Workforce Summit Planning Committee held recently. These strategies include: (1) addressing the nursing shortage as a workforce economic development issue; (2) supporting data collection, analysis, and reporting for both quantitative and qualitative data regarding the projected Indiana workforce need and supply; (3) supporting the development of creative financial assistance; and (4) promoting the "appeal" of nursing as a career. (Ms. Mitchell's written testimony is available as Exhibit 27.)

***Barbara Pantos, V.P. of Health Policy, IN Assoc. of Homes & Services for the Aging.***

Ms. Pantos described the current and future need for registered nurses, licensed practical nurses, nurse aides, and home health aides, especially for post acute and continuing care services. Nursing homes, home health agencies, adult care facilities, assisted living facilities, and other programs will encounter serious difficulties in maintaining appropriate levels of personnel. Ms. Pantos provided a number of suggestions and recommendations in the areas of: (1) improving wages and benefits; (2) dependent care issues; (3) transportation assistance; (4) employee training; (5) workforce development; (6) survey fines; and (7) research. Ms. Pantos added that, although labor shortages are a pervasive and overriding concern for the overall economy, they pose particular problems for continuing health care because such shortages can directly impact on the quality of life and well-being of vulnerable elderly and disabled persons who are dependent on these services. (Ms. Pantos' complete written testimony is available as Exhibit 28.)

The next meeting of the Health Finance Commission is scheduled for October 10 at 1 p.m. in the Senate Chambers. The fourth meeting of the Commission will be October 24 at 1 p.m. in Room 233 of the State House.

There being no further business to conduct, the meeting was adjourned at approximately 5:15 p.m.